"SETTING THE STAGE" FOR STRATEGIC PLANNING FOR ALBERTA'S CONTINUED RESPONSE TO HIV/AIDS IN THE YEAR 2000— LITERATURE REVIEW

Prepared for

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Edmonton
October 30, 1995

Alberta
HEALTH

ISBN: 0-7732-1850-5

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I
Introduction

Alberta Health, at the Minister's direction, embarked on a process to assess the current situation, emerging and future trends regarding HIV/AIDS in Alberta to prepare for planning for the Government's continued response to HIV/AIDS to the year 2000. Established in 1987, the Provincial AIDS Program has addressed the prevention, management and control of HIV/AIDS through well planned education, care and support strategies, facilitated by substantial financial commitments by the government. Over the years significant community, institutional, government and client expertise, including a large supportive network, has developed. Many of the original planning components have developed into ongoing programming while others have been completed and discontinued.

After eight years, numerous factors have affected HIV/AIDS prevention, care and support. KPMG Management Consulting was contracted to undertake some preplanning research to examine these factors and assess government's response to them, in preparation for a more formal strategic planning process.

From February to June 1995, we conducted our research:

- A **literature review** in which strategic plans of provincial, national and selected international jurisdictions were compared and contrasted, approaches to strategic planning were described and summarized, and, program guidelines and standards researched.

- Nineteen **interviews** with a cross-section of key informants involved in various facets of HIV/AIDS at the provincial and national levels representing: individuals living with HIV, a range of disciplines (physicians, nurses, social workers, educators), provincial and federal government departments (Alberta Education, Alberta Justice, Alberta Health, Health Canada), community-based organizations (AIDS service organizations, former public health units, injection drug use programs), facility-based programs (HIV clinics), and the private sector (social marketing) were conducted.

- A **provider/client survey** distributed to 215 organizations and individuals involved in HIV/AIDS prevention, education, treatment, care and support, either as service recipients or providers resulted in 67 respondents or 31% response rate.

- Ten **focus groups** of specific HIV/AIDS consumer groups and service provider groups to discuss selected issues were conducted—injection drug users, young gay men, families/women, care & support providers, formal health system providers, school education/public information providers, Provincial AIDS Program staff (the group included representation from the Medical Services Branch of Health Canada), rural community representatives (consumers and service providers), representatives of AIDS Service Organizations, and the Directors of Communicable Disease Control within Alberta Health.

This report contains our review of the literature. In the chapters that follow we describe our methodology and provide an overview of provincial, national and international HIV/AIDS strategic plans. We conclude by describing some inclusive strategic planning models. The bibliography for the literature review is contained in Appendix A.

II

Methodology

In reviewing the literature for HIV/AIDS over the last five years, we concentrated primarily on strategic or policy setting documents and on any new strategies or findings that might affect the care and prevention of HIV/AIDS.

This review was conducted using the following resources:

- Alberta Health's AIDS Collection.
- University of Alberta General Collection.
- Medline, Cinahl, Healthplan Database Searches.
- Centers for Disease Control and Prevention (CDC) AIDS Clearinghouse.
- CDC Atlanta - Media Office.
- World Health Organization (WHO).
- Internet Search:
  - HIV/AIDS Information.
  - Health:Medicine: HIV/AIDS.
  - HIVNET/GENA Information Server.

From these sources we identified a number of strategic plans that are compared and contrasted within this review. We also describe some strategic planning models.

III

HIV/AIDS Strategic Plans

HIV/AIDS strategic plans set out the main policies of government, describe objectives, target and strategies together with the outline of a plan of action and include a monitoring/evaluation framework and budget[1]. They typically include a discussion on situation, trends and strategy options, national teams, and in many cases the participation of WHO, other organizations or stakeholder input and the formulation of short and medium-term plans covering periods of up to 5 years. These plans are intended to represent broad and flexible frameworks which can be reviewed and modified at any stage, or in response to a situation such as a major epidemiological shift.

International, national and regional strategic HIV/AIDS plans were reviewed to identify the differences and commonalty of approaches to HIV/AIDS. KPMG reviewed strategic planning, care and support documentation and reviewed the plans by country or province.

A. International and national strategies

A review of eleven strategic plans and associated documents was conducted and is compared and contrasted by program characteristic in Appendix A.

1. World Health Organization's global strategy

The World Health Organization and Canada's Blueprint provide an all-inclusive approach and strategy for addressing HIV/AIDS to the year 2000.

The World Health Organization (WHO) takes a primarily sociological approach which they direct and coordinate in keeping with its mandate of the General Assembly of the United Nations. The WHO strategic plan has served as the main policy framework for the global response to the HIV/AIDS pandemic. Their strategy is to prevent infection with HIV, reduce the personal and social impact of infection and mobilize and unify national and international efforts against AIDS.

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[1] ***Global Programme on AIDS and Programme of Maternal and Child Health Including Family Planning***, *World Health Organization, May, 1990.*

In 1992, the update of the WHO global strategy[1] proposes ways of meeting the new priorities of this evolving pandemic:

1. Increase emphasis on adequate and equitable provision of health care as HIV progresses from asymptomatic infection to AIDS.

2. Expand and treat with more efficacy other sexually transmitted diseases known to increase the risk of HIV transmission.

3. Improve women's health, education, legal status and economic prospects to reduce women and their children's vulnerability to HIV.

4. Remove legal and other barriers to frank messages about sexual transmission to produce a **more** supportive social environment for AIDS prevention.

5. Plan today for the socioeconomic impact of HIV/AIDS.

6. Greater focus on effective communication to overcome stigmatization and discrimination.

National strategic approaches to HIV/AIDS are primarily based and linked to the WHO strategy and global program[2].

2. Canada's blueprint

In June of 1989 the Fifth Annual Conference on AIDS held in Montréal provided the impetus for the development of the National AIDS Strategic Plan[3]. The following goals and guiding principles were identified:

Goals

1. Stop transmission of HIV.

2. Search for effective vaccines, drugs, and therapies.

3. Treat, care for and support persons infected with HIV, their caregivers, families and friends.

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[1] ***WHO AIDS Series 11: The Global AIDS Strategy,*** *World Health Organization, Geneva, 1992.*

[2] ***1991 Progress Report: Global Programme on AIDS,*** *World Health Organization, Geneva, 1992.*

[3] ***HIV and AIDS: Canada's Blueprint,*** *1990.*

Guiding Principles

- Everyone must be involved.
- Individuals are obliged to behave responsibly.
- Those infected with HIV/AIDS must take part in program design and delivery.
- Those infected with HIV/AIDS have the same rights to confidentiality, community support and dignity as their fellow Canadians.
- Society has a duty to safeguard public health as well as a right to protect itself.
- To be effective, programs & policies must take account of regional, cultural and social diversity.
- Activities must be coordinated and resources combined.
- The approach must be multifaceted and be sensitive to ethical and human rights issues.
- There must be a commitment to immediate and long-term action.
- Canada must support WHO's Global Programme on AIDS.

The Federal Government's Commitment to Fighting AIDS[1] links the above goals and guiding principles to support initiatives and programs. The initiatives are in the areas of education and prevention, biomedical, care, treatment and support, support to non-governmental organizations and continued coordination and collaboration both within Canada and in concert with WHO.

The Canadian government also outlines its research planning process[2] that identifies partners and stakeholders in research, the existing research planning process, principles, goals and challenges. To address these issues five general goals were updated:

Goals

1. Communication.
2. Coordination.
3. Collaboration.
4. Creativity.
5. Contribution to global effort.

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[1] ***Building an Effective Partnership: The Federal Government's Commitment to Fighting AIDS,*** *1990.*

[2] ***National AIDS Strategy - Towards a National HIV/AIDS Research Planning Process: A Discussion Paper****, National AIDS Secretariat, Health Canada, November, 1994.*

The national research planning process should recognize HIV/AIDS is a multi-disciplined research field; requires both directed and investigator-initiated research; requires a combination of continuity and flexibility; requires collaboration between stakeholders and has global dimensions.

3. New Zealand's strategy for the HIV/AIDS epidemic

In 1988 the National Council on AIDS began developing a comprehensive three to five year strategy[1] with the expertise from AIDS groups and stakeholder groups. The goals of New Zealand's HIV/AIDS strategy are:

1. To minimize transmission of HIV.

2. To support, care for and to treat people infected with HIV.

3. To protect the public health without sacrificing human rights and civil liberties.

The principles of the national strategy highlight equal access, continuing co-operation with those infected and at risk as well as addressing education and partnerships.

The strategy provides a background on HIV, how it is transmitted, testing and targeted prevention strategies. These strategies target men who have sex with men, IV drug users, inmates, young people, sexual partners of people at risk, workers in the sex industry, and blood and blood product recipients. The strategy addresses public education, living with HIV, caring for people with HIV, and HIV infected persons as part of the community. The strategy is completed with a look to the future and outstanding issues and questions that need to be addressed in consequent strategies.

4. Oxford Regional Health Authority — Great Britain

The Oxford Regional Health Authority's strategic plan[2] identifies specific issues and recommendations with regard to education and treatment of HIV/AIDS. Issues that are addressed include:

- Strategy for education and prevention.
- Ethics, principles and social issues.
- Counselling, testing and consent.

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[1] ***The HIV/AIDS Epidemic: Towards a New Zealand Strategy - A Policy Discussion Paper***, *National Council on AIDS, May, 1989.*

[2] ***Towards the Control of an Epidemic: Regional Policy and Strategy for HIV and AIDS,*** *Oxford Regional Health Authority, Summer, 1990.*

Exhibit III-1
Components of Alberta's Program

Strategies	Goals	Objectives
A. Prevention and Control	1. Increase the public's understanding of HIV infection and aids and encourage them to adopt lifestyles free of risk of infection and without fear.	1.1 Increase public knowledge and reduce fear of HIV infection and AIDS. 1.2 Increase knowledge by teachers, education officials and other professionals involved in education. 1.3 Increase knowledge by youth and adolescents of health lifestyles and sexuality.
	2. Prevent the spread of HIV infection.	2.1 Reduce and eventually eliminate transmission through sexual contact. 2.2 Eliminate spread of infection by blood and blood products. 2.3 Prevent spread of virus from infected women to infants. 2.4 Prevent spread through accidental exposure in workplaces where blood, etc. is handled. 2.5 Prevent spread of infection by drug abuse.
B. Education of Workers	3. Increase health workers' knowledge.	3.1 Increase education of and by health professionals. 3.2 Improve infection control measures in health care facilities.
	4. Increase knowledge in the workplace.	4.1 Increase knowledge of employers & workers.
C. Epidemiological surveillance and assessment.	5. Monitor rates of infection with the virus which causes AIDS.	5.1 Continue to monitor HIV antibody seropositivity and AIDS. 5.2 Study rates of the infection among groups of people who engage in risk behaviours.
	6. To determine the occurrence of workplace risk factors.	6.1 Determine the nature and extent of the hazard of acquiring the virus at work.
D. Laboratory diagnosis and screening	7. To ensure that assessment and screening are available for individuals likely to be infected.	7.1 Make medical assessment in regard to the infection available and accessible. 7.2 Enhance screening and counseling programs.
E. Care and treatment programs.	More detailed plans, including goals and objectives will be in a plan for care programs (March 1988).	
F. Research initiatives	8. To research outcomes of prevention, control and treatment goals.	8.1 Increase funding by and to Alberta agencies for AIDS-related research. 8.2 Assess the impact and effectiveness of the prevention and control program.

- Control of infection.
- Health care workers with HIV or AIDS.
- Staff training and support.
- Treatment and care: a multi-agency strategy.
- Services for people with asymptomatic HIV infection.
- Care of people with HIV or AIDS.
- The role of the primary care team.
- Dental services.

The Oxford Regional Health Authority identifies education and prevention as the most important areas in HIV/AIDS work. Primarily, the Authority monitors the epidemic, disseminates information and promote examples of good practice.

B. Provincial strategic plans

1. Education and Caring: Alberta's Program for AIDS

In 1987 Alberta Community and Occupation Health outlined an AIDS program for Alberta[1]. Exhibit III-1, *(opposite page)* demonstrates how Alberta's strategic plan ties specific strategies to goals and objectives. The two main problems stated for Alberta with respect to AIDS are how to control the infection and how to best care for those who are already infected. The primary defense stated against AIDS is community-based public education.

The program continues by outlining the situation in Alberta, the educational approach, risk factors and prevalence, what HIV/AIDS is all about and related plans for prevention and control.

In 1989 the Working Group on AIDS Patient Care Services developed a comprehensive and coordinated provincial plan[2] for services and programs in the inpatient, outpatient and community care sectors. The plan outlined HIV/AIDS in respect to Alberta and specific care requirements of individuals diagnosed with HIV/AIDS. In response to the report *Caring for People with HIV Infection/AIDS*, six policy guidelines were developed for the provision of services:

- **Integration of care and treatment.** The care and treatment of people with HIV/AIDS will be integrated within the existing health care system (acute care, long term care, palliative care, home care and community care) which will be strengthened as necessary to meet the needs of affected individuals.

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[1]***Education and Caring: Alberta's Program for AIDS,*** *Alberta Community and Occupational Health, October, 1987.*

[2]***Caring for People with HIV Infection/AIDS: A Report of Alberta's Working Group on AIDS Patient Care Services,*** *Alberta Health, May, 1989.*

- **Multi-disciplinary services.** A full range of health and psycho-social services should be available to meet the multiple and complex needs of affected individuals and their families.

- **Outpatient and community care services.** Outpatient and community-based services will be used to the fullest extent possible to enable affected individuals to live in their own homes.

- **Education of health and social service workers.** The importance of making educational programs available throughout the province for health, social services and related professionals, is recognized.

- **Infection control precautions.** Blood and body fluids precautions as recommended by the Laboratory Centre for Disease Control will be used throughout the health care system to help prevent the transmission of HIV and other blood-borne viruses.

- **Management of patient care issues.** Special study groups will be developed as required to investigate and provide recommendations for the resolution of legal, ethical, treatment, financial and social issues related to the care of people with HIV infection/AIDS.

Together, these two documents provide policies and care, treatment and projections for HIV/AIDS in Alberta.

2. British Columbia Provincial HIV/AIDS Strategy and Work Plan

British Columbia's provincial HIV/AIDS strategy[1] is divided into a strategy and work plan document supplemented by notes from the Minister of Health in support of the initiatives described in the strategic plan. The goals of this plan are to prevent further spread of HIV/AIDS, provide the people infected with HIV with appropriate treatment and support and contribute to national and worldwide efforts to control HIV/AIDS.

To accomplish these goals the British Columbia government identifies three strategic areas: education and prevention, treatment and related issues and research. Each of these areas has associated objectives, current programs and activities and priorities identified. The workplan's overriding approach is coordinated consultation between the government and stakeholders. It also re-states the strategic areas and identifies specific funding and program initiatives. In conclusion, the strategy includes a glossary of terms and states the mandates of specific organizational bodies.

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[1] ***British Columbia Provincial HIV/AIDS Strategy and Work Plan**, B.C. Ministry of Health, April, 1991.*

Eleven strategic areas are identified:

1. HIV/AIDS and the gay community.
2. Rights of HIV/AIDS persons.
3. Education/prevention for students.
4. Housing and social assistance for persons with HIV/AIDS.
5. HIV/AIDS and prison inmates, corrections officers and others working in prisons.
6. HIV/AIDS in the workplace.
7. Intravenous drug users and HIV/AIDS.
8. HIV/AIDS and native people.
9. Compensation issues for hemophiliacs and users of HIV-infected blood products.
10. Women and children.
11. Multi-cultural language issues.

Goals are tied to strategies which are tied to objectives, current programs and priorities which, in turn, are tied to funding and program initiatives. This approach is mirrored in the strategic plan of Ontario to the Year 2000.

*The Province of British Columbia is currently revising the strategic plan, to be released late in 1995.

3. Saskatchewan Provincial HIV/AIDS Strategy

The Saskatchewan Provincial HIV/AIDS Strategy[1] is a summary document highlighting the mission of Saskatchewan Health and its perspective on its role in preventing HIV/AIDS in Saskatchewan and as a member of the global village. The mission of Saskatchewan is holistic and inclusive.

The main elements of Saskatchewan's strategy are a glossary of terms, mission statement, a historical review of Saskatchewan's involvement with this issue, strategy conclusion and division of responsibility. The appendices provide background on the following perspectives:

- Historical
- Clinical
- Testing
- Statistics
    - World-wide
    - Canadian
    - Saskatchewan
    - Predictions for Canada

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[1] ***Saskatchewan Provincial HIV/AIDS Strategy: Phase I,*** *Saskatchewan Health, July, 1993.*

The focus of the strategic plan is integrating care and prevention programs and services. Specifically, Saskatchewan Health intends to provide fair and reasonable access to comprehensive and well-rounded care and services to all. The plan also takes a holistic approach in that it considers all aspects in treating the people infected with HIV physically, spiritually and emotionally. The plan is inclusive in that it includes input from the people infected with HIV, and involves communities, families and individuals in the educational and support processes.

Note: Phase II of Saskatchewan's HIV/AIDS Strategy is completed but not yet released.

4. Ontario's HIV/AIDS Plan to the Year 2000

Ontario's strategic approach on HIV/AIDS[1] is to prevent the spread of HIV infection and improve quality of life. The province strives to:

- Maintain and refine the existing HIV/AIDS infrastructure and build on its strengths.
- Focus efforts and direct activities where they will be most effective.

Ontario's HIV/AIDS plan is based on the following principles:

1. Community Mobilization — community development approach.
2. Accessibility — regardless of geography and income, and, sensitive to gender, culture, age and sexual orientation.
3. Proven Interventions/New Knowledge — investment in proven interventions, successful treatments and prevention techniques.
4. Empowerment — consultation with people living with HIV.
5. Comprehensiveness/Responsiveness/Co-ordination — recognizing that HIV/AIDS is a complex social issue and coordinate with other agencies, programs and stakeholders.
6. Balance prevention efforts with care and support services. A larger percentage of financial resources may be allocated to provide care but not at the expense of prevention efforts.
7. Health Promotion — enable HIV infected persons, caregivers and the public to adopt healthier behaviors and practices.

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[1] ***Building on Our Strengths: Focusing Our Efforts: Ontario's HIV/AIDS Plan to the Year 2000,*** *Ministry of Health, Ontario, December, 1993.*

Exhibit III-2
Ontario's HIV/AIDS Plan to the Year 2000

The following is a summary of Ontario's HIV/AIDS plan to the year 2000. The priorities to the year 1995 are circled.

Prevention	Care and Support	Professional Education	Research	Supportive Environments
1. Prevent the spread of HIV in populations with the highest • Men who have sex with men. • People who inject drugs or other substances, and their sexual partners. • People who know they are infected. • People with sexually transmitted diseases • Sex trade workers and their clients. • Inmates in correctional facilities. 2. Prevent the spread of HIV in populations with lower incidence but whose sexual activities put them at high risk • Women. • Young people. • Ethnocultural communities. • Aboriginal peoples. • People with physical, mental or developmental disabilities. 3. Prevent the spread of HIV in health care settings.	1. Promote early testing and diagnosis. 2. Ensure people with HIV have access to social support, peer support, employment, housing and financial security. 3. Ensure access to the best possible medical care and treatment. 4. Ensure appropriate co-ordinated care and support for groups that have special needs. • People infected through the blood supply. • People with HIV and an addiction. • Women. • Children. • Families. • Youth. • Ethnocultural communities. 5. Provide the best possible palliative care for people in the later stages of AIDS. 6. Develop a fully planned, co-ordinated system of care.	1. Increase the number of family physicians caring for people with HIV/AIDS. 2. Educate counselors and others in the psychosocial fields about the needs associated with HIV.	1. Epidemiologial research • More accurate/complete data collection. • Prevalence studies. • Natural history of HIV disease. 2. Basic science • Molecular biology. • Immunology. • Markers of disease. • Application to vaccines/therapeutics. 3. Clinical research • Clinical trials. • Non-pharmaceutical treatments. • Observational database. 4. Psychosocial research • Social attitudes. • Efficacy of prevention programs. • Innovative support programs. • Effect of psychosocial services on quality of life and disease progression.	1. Provide a supportive legal and policy environment that will prevent discrimination. 2. Counter social attitudes that stigmatize people with HIV/AIDS. 3. Encourage infected people who are willing to speak out and take part in planning programs and services. 4. Promote an environment that promotes health. 5. Provide support for the partners, families, friends, caregivers and others affected by HIV.

The Ontario plan addresses situations, proposed activities and expected outcomes in the areas of prevention, care and support, professional education, research and supportive environments. Exhibit III-2 (*opposite page*) highlights the priorities to the year 2000.

The focus of the Ontario strategic plan is to describe specific groups within society and identify proposed activities to limit HIV infection and expected outcomes. The groups identified are:

- men who have sex with men.
- people with STDs.
- street youth.
- women.
- ethnocultural communities.
- men integrated into gay community.
- sex trade workers and their clients.
- inmates in correctional facilities.
- young people.
- aboriginal peoples.
- people with physical, mental or developmental disabilities.
- men who are not integrated into gay community.
- people who inject drugs or other substances and their sexual partners.
- people who know they are infected.

Ontario's strategy towards combatting AIDS takes an inclusive approach by closely reviewing different segments of the population and identifying both communication vehicles and interventions that may affect both behaviour and the incidence of HIV/AIDS.

5. Québéc Strategy for Combatting AIDS and Preventing Sexually Transmitted Diseases

The Québéc government developed a strategy in 1988 for combating HIV/AIDS and sexually transmitted diseases (STDs) that stressed prevention, development of care and services, maintenance of a tranquil social climate for persons suffering from HIV/AIDS, and evaluation and development of research.

In 1991 they revisited this strategy[1] and moved to a multi-disciplined, holistic approach. This approach is aimed at preventing HIV/AIDS and STDs, improving the quality of care and services and promoting non-discrimination and compassion towards victims. Specific risk groups identified include: young people in school or having difficulty, men who have homosexual relations, IV drug users, women and children, aboriginal communities, prisoners, hemophiliacs and the homeless.

Overall, the Québéc approach identifies risk groups and action steps for the ministere de la Santé et des Services sociaux including activities, communication strategies and development of specific programs or systems.

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[1] ***Québec Strategy for Combatting AIDS and Preventing Sexually Transmitted Diseases, Phase 3: Action Plan for 1992 to 1995,*** *Government du Québec, Ministere de la Santé et des Services sociaux, Centre québécois de coordination dsur le sida, 1992.*

6. Nova Scotia AIDS Strategy

The most recent Nova Scotia AIDS Strategy[1] was created out of a consultive process beginning in 1987 when a Task Force on AIDS was established resulting in the Advisory Commission on AIDS. Specific strategies and recommendations are detailed in a report by the Nova Scotia Task Force on AIDS[2]. This document describes the illness in detail and looks at the worldwide epidemiology as well as identifying program initiatives around education, care and support and ensuring rights for those that have contracted HIV/AIDS. Public meetings, costing and program initiatives are recommended.

This Commission consulted with government departments and members of local AIDS Service Organizations that had demonstrated leadership in responding to HIV/AIDS. The strategy is descriptive and covers education and prevention, protection, care, treatment, support and research. Statistics reviewed were:

- HIV cases by year.
- HIV cases by age group and gender.
- HIV risk factors (1990-1992).
- AIDS cases by year.
- AIDS cases by age group and gender.
- AIDS risk factors (1983-1992).
- Average rates of AIDS by health unit (1989-1991).

In June 1994, the Nova Scotia Advisory Commission on AIDS (NSACA) reviewed its goals, objectives and activities from 1989 and 1992[3] and looked toward 1995[4]. Prevention and care objectives from the 1992 strategy, were reviewed, culminating in a progress report. The Commission identified the following emerging issues:

- **Health care reform** and AIDS - monitor the shift to decentralize to regional community health boards and ensure that AIDS is not ignored.
- Continue **monitoring the implementation** of the Nova Scotia AIDS strategy and recommend revisions as required.
- Continue in **facilitation role** between government and community.

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[1] ***Nova Scotia AIDS Strategy,*** *Government of Nova Scotia, December 1993.*

[2] ***The Challenge of AIDS: A Nova Scotian Response.*** *Report of the Nova Scotia Task Force on AIDS. Province of Nova Scotia, September, 1988.*

[3] ***Nova Scotia Advisory Commission on AIDS - Strategy: 1992 to 1995,*** *March, 1992.*

[4] ***Nova Scotia Advisory Commission on AIDS: Past, Present and Future*** *- A Progress Report on the Work of the Nova Scotia Advisory Commission on AIDS, June, 1994.*

Exhibit III-3
Newfoundland's summary of HIV/AIDS prevention and education programming for sexually active adults

Health Promotion Mechanisms	Community Partners	Objectives	Implementation Strategies	Impact
Peer Education	• Home and school associations. • Service clubs. • Adult church groups. • Nfld. & Labrador AIDS Committee (NLAC). • Sports associations. • Pubs. • Men's and women's groups. • Unions. • Employers. • Planned Parenthood. • Regional health units. • Aboriginal communities.	Knowledge: • Distribute relevant AIDS and sexuality information to the membership. • Include AIDS prevention and education issues on the agenda of local, regional and provincial meetings, workshops, conferences and newsletters.	• Provide appropriate print and audiovisual learning resources. • Access appropriate speakers to educate the membership. • Utilize opportunities to promote publicly the organization's role in AIDS prevention and education.	• Awareness of HIV/AIDS (consciousness-raising). • Community education. • Leadership (when AIDS-related issues are raised, groups can respond from a position of leadership).
Self-Help	Same as above	Attitude: • Facilitate awareness of personal risk behaviours.	• Provide explicit information on harm reduction/safer sex behaviours. • Provide skills training. • Provide information on available community services.	• Communication around self-protective behaviours. • Improved comfort about sexuality issues. • Utilization of services.
Advocacy/Healthy Environments	Same as above	Behaviour: • Promote community-based sexuality education programs. • Promote positive sexuality messages and modeling of sexually healthy behaviours.	• Participate in training programs for adults. • Form linkages with other partners to identify sources of funding for local initiatives (e.g., training workshops, conferences, etc.). • Lobby retail outlets to sell condoms.	• Acquisition of relevant skills. • Self-protective behaviours as the cultural norm. • Coalition building. • Improved availability of and accessibility to condoms.

- Facilitate **continuing education** mechanisms to foster cooperation between government health and education professionals.
- **Monitor federal policies** such as the immigration policy and the Federal AIDS strategy to advise the Minister about local implications.
- Examine **alternative therapies** for HIV infection and make recommendations regarding drug coverage to the Department of Health.
- Monitor the rise in **AIDS-related tuberculosis** and make recommendations.
- Monitor **emerging HIV/AIDS-related issues** and alert the Minister of Health.

The Nova Scotia AIDS Strategy is the most closely monitored, communicated and evolved strategy of all the Canadian strategic plans reviewed.

7. Newfoundland and Labrador Development of a Comprehensive HIV/AIDS Strategy

The strategic approach laid out by the Government of Newfoundland and Labrador[1] is similar to Alberta Health's working group document on Caring for People with HIV/AIDS infection.

Newfoundland's document did not go into as much detail concerning care and treatment issues and specific services as the Alberta working group document. However, Newfoundland focused on **prevention and education**, testing and treatment, and the economic impact of HIV/AIDS. Exhibit III-3 (*opposite page*) describes the health promotion mechanisms, community partners, objectives, implementing strategies and impact aimed at the intended audience of sexually active adults.

The provincial governments of Manitoba, New Brunswick and Prince Edward Island are in the process of developing AIDS strategic plans.

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[1] ***Towards the Development of a Comprehensive HIV/AIDS Strategy for Newfoundland and Labrador: Report of the Working Groups on Prevention and Education and Treatment Care and Home Support,*** *Government of Newfoundland and Labrador Department of Health, Department of Health, December, 1993.*

C. Strategic policy perspectives of industrialized democracies

In reviewing different strategic plans distinct differences in approach both within provincial provinces and between countries were identified. A critical policy review of each country's perspective is described in AIDS in the Industrialized Democracies[1]. Contributors from each of eleven countries provided a perspective on the approach taken to the care, prevention and treatment of HIV/AIDS. The countries represented are the United States, Spain, Japan, France, Britain, Sweden, Canada, Germany, Denmark, Australia and The Netherlands. Developing strategic approaches to HIV/AIDS is challenging to each country due to the nature of the disease.

> "HIV/AIDS is incurable, afflicts marginalized or threatened populations with historically rooted fears about the state and antagonisms to its institutions, carries with it great stigma, requires modifications in the most intimate behaviors that are difficult to undertake and sustain, and is primarily transmitted in contexts that involved well-defined sexual acts or the sharing of drug injection paraphernalia by consenting adults. The first decade of the epidemic gave rise to an alliance of gay leaders, proponents of privacy, physicians and public health officials that sought to foster the inclusion of those with HIV or at risk of HIV infection rather than advocating their control."[2]

The significant differences between how western industrialized countries address AIDS is summarized below:

1. AIDS is treated like any other venereal disease with harsh commands by the Swedish government unlike the other industrialized democracies.

2. Regulations on closing bathhouses was undertaken by public health officials in New York City and San Francisco but this was rejected by officials in Australia, the Netherlands, and Denmark.

3. Needle exchange programs are not controversial in the Netherlands but are of some concern in the United States and Germany.

4. AIDS campaigns are designed to raise fears about AIDS in the general public in Britain, Sweden and Australia but not in Holland, France, Spain or Denmark.

5. School children with AIDS was controversial in Spain and the United States but not elsewhere.

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[1] ***AIDS in the Industrialized Democracies: Passions, Politics and Policies,*** *edited by David Kirp and Ronald Bayer, 1992, pp.1-6.*

[2] ***AIDS in the Industrialized Democracies: Passions, Politics and Policies,*** *edited by David Kirp and Ronald Bayer, 1992, pp. 364-365.*

6. Studies to track the epidemiology of HIV infection were not controversial in Canada and the United States but not in Great Britain and Holland.

7. Special financial awards to hemophiliacs infected with HIV, contracted from contaminated blood clotting agents, have been made in Denmark, Great Britain, Japan and *Canada*[1].

Each country is tackling challenging health care and support issues associated with HIV/AIDS within its own unique medical, social, legal and moral climate. The higher challenge comes with cooperation and collaboration between industrialized countries, and ultimately, throughout the world.

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[1]*Since the publication of AIDS in the Industrialized Democaracies, Canada has also made financial awards to recipients of tainted blood and blood clotting agents.*

IV

Inclusive Strategic Planning Models

Strategy can be defined as "the plans and activities developed by an organization in pursuit of its goals and objectives, particularly in regard to positioning itself to meet external demands relative to its competition[1]." This definition emphasizes changing an organization to meet the demands of the environment but overlooks the possibility of affecting the environment to be more favorable to the organization's aims. On the other hand, interactive planning works toward designing a desirable future and invents ways of bringing it about. Following are two strategies including stakeholder involvement as a component or key aspect of the approach. Strategic issues management systems is a proactive approach to strategic planning.

A. Strategic issues management systems

Strategic issues management systems (SIMS) provide an integrated approach to dealing with external policy matters and expands current strategic management activities. With this system additional resources are required for new analyses and interpretations and for more intense interaction with stakeholders.

Central to this model is issues management. An issue is a point of conflict between an organization and one or more of its stakeholders. Exhibit IV-1 describes the four categories of issues - universal, advocacy, selective and technical.

[1] ***Strategic Choices for America's Hospitals***, *Shortell, S.M, Morrison, E.M., and B. Friedman, 1990.*

Exhibit IV-1
Four types of issues

Type	Example
Universal issues have serious and imminent effects on a large number of people. Government action is expected since the issues are beyond the scope that can be handled by a private organization.	HIV/AIDS; Energy Crisis
Advocacy issues by groups claiming to represent the broad public interest. Once again the broad scope of the problem suggests that government intervention is appropriate.	Health insurance reform
Selective issues affect special interest groups. The cost of dealing with these issues, however, is generally passed on to the general population.	Medicare reimbursement that results in cost shifting
Technical issues are of little direct interest to the general public and are left to the experts. Note, however, that an advocacy group may shift a technical issue to another category by redefining it. For instance, steps to improve internal efficiency may be characterized as a threat to care.	Hazardous waste disposal that can be characterized as creation of an environmental threat

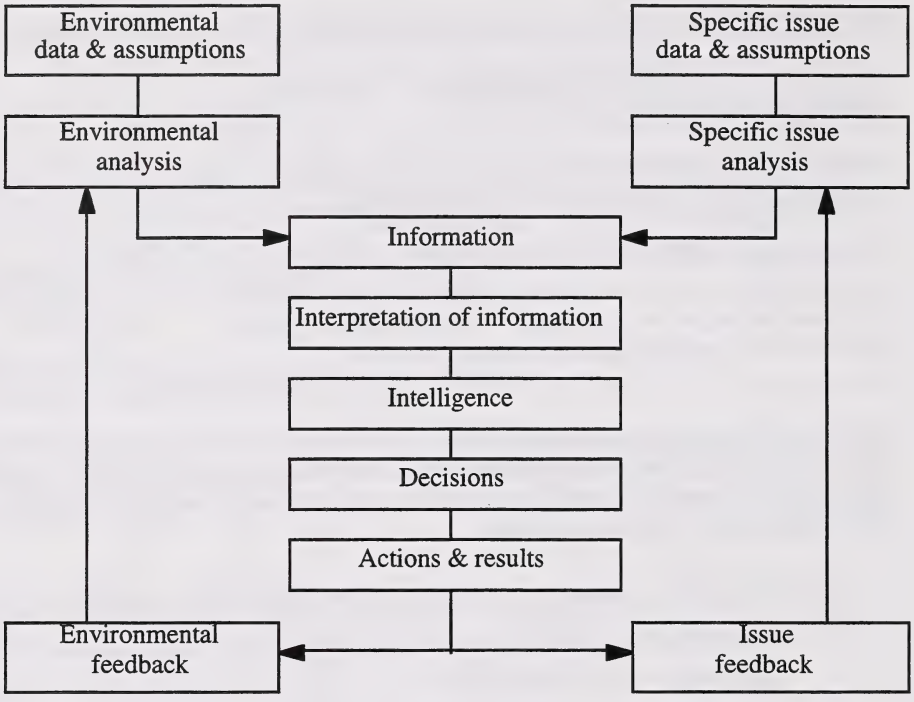
The identification of potential issues that may affect the organization and the mobilization of resources to strategically influence the course of those issues is key. Issues management is most effective when fully coordinated with the planning process. Issues management functions include:

1. Integrating public policy issues analysis into corporate strategic planning.
2. Monitoring standards of organizational performance to discover the opinions and values of key stakeholders that may affect the organization's operation.
3. Developing and implementing codes of social accountability.
4. Assisting senior managers in making decisions about goals and operations that will influence or be influenced by public opinion.
5. Identifying, analyzing and prioritizing the issues of greatest importance to the organization.
6. Creating proactive plans for strategic responses to significant issues.
7. Carrying out the external communications part of the response plan.
8. Evaluating the effectiveness of the organization's issues management program.

Developing an effective SIMS requires careful preplanning. The organization begins by clarifying the system's purpose, creating a formal structure for the SIMS and developing standards for environmental scanning and analysis and reporting. An organization can be

enhanced with a focus on both outputs and processes. For example, an issue's significance can be examined by using a two-dimensional matrix based on the issue's significance and the organization's ability to influence the development of the issue. Issues of great significance amenable to intervention would be targets for allocation of a larger portion of resources. Exhibit IV-2 outlines the SIMS:

Exhibit IV-2
Strategic issues management system



The SIMS is most effective when it becomes an integral part of existing strategic planning or management of a program. Initial phases of the SIMS utilizes existing data collection and analyses of the strategic environmental scanning process.

B. Stakeholder approach

The stakeholder approach[1] helps integrate managerial concerns such as strategic management, marketing, human resource management, organizational politics and social responsibility. Stakeholders are individuals, groups or organizations who have an interest

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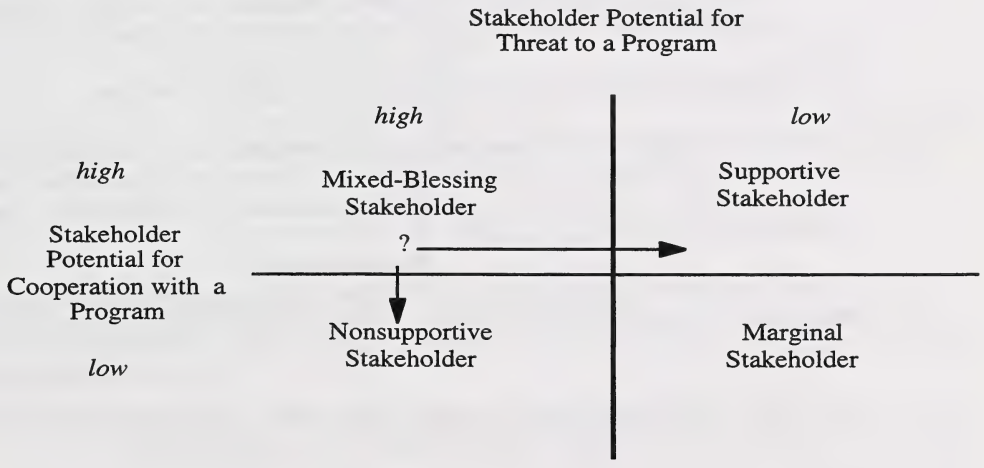
[1] *"Too Many on the Seesaw: Stakeholder Diagnosis and Management for Hospitals,"* ***Hospital & Health Services Administration****, Volume 33, Number 2, Summer, 1988.*

in the actions of an organization and the ability to influence. In the case of HIV/AIDS strategic planning stakeholders may include community based organizations, Regional Health Authorities and professionals as well as institutions such as correctional facilities. Health authorities or departments must effectively manage their relationships with relevant stakeholders to ensure effective cooperation and communication.

The stakeholder approach identifies four types of stakeholders based on their potential for threat or cooperation with a program or initiative. Exhibit IV-3 demonstrates the four stakeholder types. The supportive stakeholder supports the goals or actions of a program and rates low on potential for threat and high on potential for cooperation. The marginal stakeholders are not rated highly as a threat or cooperatively. They may have a potential stake in the program but do not perceive the program to be relative to themselves. The non-supportive stakeholders rate high on potential for threat and low on potential for cooperation. There is also the mixed-blessing stakeholder who rates high on potential for threat and cooperation. This may include health care providers. The mixed-blessing stakeholder can be more or less supportive, depending upon the situation.

Exhibit IV-3
Diagnostic typology of hospital stakeholders



Sakeholder involvement is optimized by tailoring strategies for each type of stakeholder. Program administrators can maximize supportive stakeholders' cooperation by:

- Involving supportive stakeholders in relevant issues or activities.
- Monitoring the marginal stakeholder or special interest group.
- Defending against the non-supportive stakeholder.
- Collaborating with the mixed-blessing stakeholder.

The goal to managing stakeholder types and their expectations is to increase the support of a program from diversified groups of stakeholders.

C. Considerations for HIV/AIDS strategic planning and evaluation

Effective planning is key to effective prevention, care and support for HIV/AIDS. The WHO has identified six strategies for National AIDS prevention and control programs[1].

1. **Prevention of sexual transmission.** This will require dissemination of information and education leading to long-term changes in sexual behaviour.

2. **Prevention of transmission through blood.**

   (a) Prevent HIV infection through blood transfusion.

   (b) Three distinct situations requiring action for prevention of transmission through injections and skin-piercing instruments:

   - self injection by drug users;
   - injections or other invasive procedures in medical practice;
   - injections and other invasive procedures outside medical practice.

   All equipment and instruments used for injections or other skin-piercing procedures, both within and outside the medical system, must be sterile.

   (c) Prevention of transmission through organ and semen donation.

3. **Prevention of perinatal transmission**. Approaches include behavioral and operational research, dissemination of information, education and communication, and the counselling of women of childbearing age, particularly those infected with HIV.

4. **Prevention of transmission from HIV-infected persons through the use of therapeutic agents**—drugs that reduce or eliminate the amount of HIV in the body.

5. **Prevention of transmission through vaccination**. Candidate vaccines are being developed although not yet available.

6. **Reduction of the impact of HIV infection on individuals, groups and societies**. Counselling HIV-infected persons and their sexual partners, families, and other relevant groups, strengthening community services.

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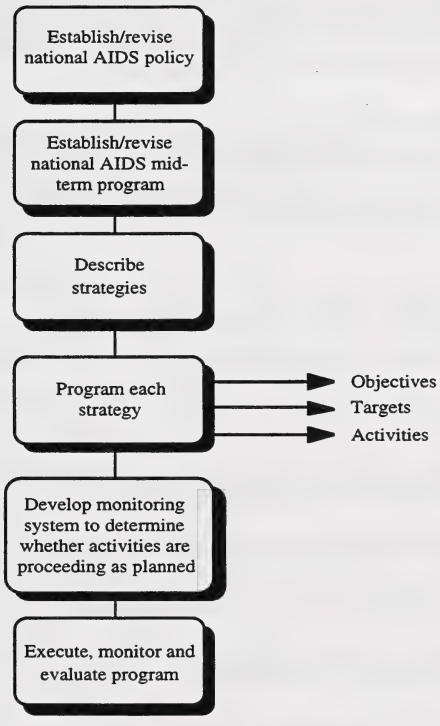
[1] ***WHO AIDS Series 4: Monitoring of national AIDS prevention and control programmes - Guiding Principles***, *World Health Organization, Geneva, 1989.*

The WHO also suggests a program management approach for planning, implementing and monitoring AIDS programs and is demonstrated in the exhibit following.

Exhibit IV-4
Program management flowchart



The WHO has also put forward national program objectives, outlined in Appendix C. A number of objectives cited directly affect the direction of provincial or local HIV/AIDS planning and include:

- Decentralizing national AIDS program activities to regional, district and community levels.
- Developing mechanisms to increase the involvement of non-governmental organizations in program planning and implementation.
- Promoting the integration of national AIDS programs with other components of the health system, particularly programs on maternal and child health/family planning (MCH/FP) and control of sexually transmitted disease.
- Ensuring technical cooperation in areas of health promotion, condom services, epidemiological surveillance, laboratory and blood transmission services, health care and counselling.

- ► Increasing the production of health promotion material and design of systems.
- ► Strengthening health/social service needs assessment and planning.
- ► Providing clinical management and support of HIV-infected persons.

Prevention measures will suffer unless national AIDS programs are capable of increasing their cost-effectiveness, for example by making more use of existing infrastructure and devising creative, lower cost approaches to individual care.

Evaluation of HIV/AIDS programs may appear to be a luxury but is crucial for program reorientation. One study[1] provides specific recommendations for the evaluation of programs, focusing on prevention of sexual transmission of HIV as the major cause of HIV transmission. The recommended methods for evaluation of national HIV/AIDS programs include:

- Surveying knowledge of preventive practices.
- Reviewing records on condom availability.
- Surveying on condom access.
- Surveying reported non regular sexual partners.
- Surveying reported condom uses in relationships of risk.
- Survey health facilities on STD case management.
- Conduct a sero-survey on STD prevalence of women.
- Survey on reported STD incidence of men.
- Conduct a sero-survey on HIV prevalence of women.

The WHO's Global Programme on AIDS has developed a framework for the evaluation of the prevention aspects of national AIDS programs. Evaluation of programs need to focus on the program implementation process not HIV prevalence as an indicator of program success or failure. The suggested steps include the collection of relevant published data at national and local levels on the political and administrative context, demography and economy of the health sector. Emphasis should be on factors relevant to sexual behaviour and situations enhancing risk during sexual encounters, as well as on health and social services infrastructure. Program targets need to be identified with the level of implementation documented. The program evaluation analysis must be thorough and include breakdowns by sex, age and geographical location.

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[1] *"Editorial Review: Prevention indicators for evaluating the progress of national AIDS programmes," Mertens, T, Carael, M, Sato, P, Cleland, J., Ward, H and Smith, G.D.,* ***AIDS****, Volume 8, Number 10, 1994.*

Of the evaluations conducted, the experience has mobilized program managers, clinicians and other stakeholders to plan for improvements in the areas of condom supply, STD case management, and interventions for behavioural change. This result supports the necessity of integrating evaluation into program formulation.

The Centers for Disease Control and Prevention in the United States suggests specific steps for setting priorities and managing HIV-related public health programs.

Exhibit IV-5
Basic steps in models of decision analysis

1. Identify the **key decision** to be made. For example: Which HIV-prevention programs should be implemented?
2. Identify the main **people who have a stake** in the decisions to be made.
3. Identify the **perspective** to be taken in the analysis. (Possible perspectives include those of society, business, government, or an individual).
4. Identify the **"time horizon"** to be considered. For example: Is the plan to be for one year, five years, 10 years? More?
5. Identify the **alternatives** (e.g., programs) among which a choice is to be made. For example, various prevention programs are "alternatives."
6. Identify the **attributes** on which the alternatives will be judged. For example, an intervention could be judged by attributes such as: Is the intervention effective? Is it cost-effective? Is it acceptable to the community?
7. Identify the **relative importance** (weighting) of the various attributes. For example, is the effectiveness of an intervention more important to a community than its cost-effectiveness? Than its cost?
8. Identify the sources of uncertainty about the ability of various alternatives to achieve certain outcomes. For example: What is the **probability** that a particular risk-reduction counselling program will lead to a certain percentage increase in its clients' use of condoms?
9. To reach a decision, a planning group might combine all of the above information using a **decision rule**. For example: One might combine information about an intervention's attributes (effectiveness, cost-effectiveness, etc.) with the relative importance assigned to each of those attributes.
10. Identify the **sources of uncertainty** about the value that was assigned to any of the attributes, weight, or probabilities described above. Use this information to perform a special analysis to learn how responsive the prioritization is to changes in the values assigned to these variables. For example: If the planning group has ranked its priorities using the cost-effectiveness of an intervention as its most important criteria in making decisions, how will its ranking of priorities change if the effectiveness of an intervention is made the most important criteria?

V

HIV/AIDS Program Guidelines And Standards

This international literature review did not yield source documents on HIV/AIDS program guidelines or standards. In reviewing strategic plans and associated literature for Canada, the United States, documents released freely on the Internet by community-based organizations as well as WHO and the CDC, no guidelines or standards were available or mentioned outside of clinical standards and practice guidelines. Some of these guidelines have been referenced and include:

- 1989 Report of the U.S. Preventive Services Task Force: Guide to Clinical Preventive Services.
- AIDS Prevention: Guidelines for MCH/FP Programme Managers.
- Counselling Guidelines for Human Immunodeficiency Virus Serologic Testing.
- Global Programme on AIDS and Programme of Maternal and Child Health Including Family Planning.
- Local HIV Policies Resource Guide.
- U.S. Department of Health and Human Services Agency for Health Care Policy and Research.

Other guidelines published provide information on funding to community-based organizations. Health Canada and the Centers for Disease Control in the United States have published these resources to assist organizations in obtaining funding and continued support for HIV/AIDS programs.

Our findings reinforce the need for the development of provincial HIV/AIDS program standards and guidelines, particularly in light of health reform and the increasing devolvement of service responsibilities to Regional Health Authorities.

Appendix A

Bibliography

Appendix A

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Appendix B

Characteristics of Strategic Plans

Appendix B

Characteristics of Strategic Plans

The Characteristics of Strategic Plans matrix identifies key program characteristics and identifies the inclusion of these characteristics for eleven strategic plans. We also included in the review associated documentation or working group documents as part of the analysis. The plans are from the following organizations/areas:

►	World Health Organization	WHO
►	Canada	Cdn
►	Alberta	AB
►	British Columbia	BC
►	Saskatchewan	SK
►	Ontario	ONT
►	Québec	QUE
►	Newfoundland	Nfld
►	Nova Scotia	NS
►	United Kingdom, Oxford Region	UK
►	New Zealand	NZ

Program Characteristic	WHO	Cdn	AB	BC	SK	ONT	QUE	Nfld	NS	UK	NZ
YEAR OF PLAN	1987	1990	1987	1991	1993	1993	1988	1993	1993	1990	1988
AIDS Situation	√	√	√		√	√	√	√	√	√	√
World statistics	√	√	√		√	√	√		√		√
National statistics	√	√	√		√	√	√	√	√	√	√
Regional statistics	n/a	√	√		√	√	√	√	√	√	√
Trends and projections	√	√	√		√						
HIV/AIDS disease description	√		√		√			√	√	√	√
Program Management	√		√	√		√					√
Coordination with WHO	n/a	√	√	√							√
Coordination with National program(s)	√	n/a	√	√		√			√		n/a
Coordination at local levels	n/a	√	√	√		√	√	√		√	√
Monitoring and evaluation	√	√	√	√							√
Program reviews	√	√	√	√	√				√		√
Program indicators	√	√									
Management information systems	√			√							
Financial support to/from national AIDS programs	√	√	√	√		√	√				√
Financial planning and management	√			√			√			√	√
Resources, obligations and monitoring	√			√		√					√
Budget preparation	√						√				√
Second generation medium-term planning	√	√	√	√	√	√		√	√		√
Program Direction	√	√	√	√	√	√	√		√	√	√
Updating AIDS strategy	√	√	√								
Advocacy	√	√	√	√		√					
Placing AIDS on global and regional agendas	√	√	√			√					
High-level advocacy	√	√		√							
World AIDS Day	√			√							
Advisory Bodies	√	√	√	√		√					
Global Commission on AIDS	√		√								
Development agencies	√	√	√			√					
Research services	√	√	√			√					
Participation and Liaison	√		√			√					
AIDS societies and conferences	√	√	√	√		√					
Non-governmental organizations (NGOs) or Community-based organizations (CBOs)	√	√	√			√			√	√	√
Emerging Policy Issues			√								
Preventing HIV transmission in health care setting	√		√								
HIV transmission and breast-feeding	√										

Program Characteristic	WHO	Cdn	AB	BC	SK	ONT	QUE	Nfld	NS	UK	NZ
YEAR OF PLAN	1987	1990	1987	1991	1993	1993	1988	1993	1993	1990	1988
Program Direction (continued)											
Human rights	√			√	√	√	√		√		√
Group at risk or targetted*											
General Public			√					√		√	
heterosexuals	√	√								√	√
homosexual/bisexuals		√	√								√
homosexual/bisexuals + injection drug users		√							√		√
Men who have sex with men	√	√				√	√	√	√		√
Men integrated in gay community						√					
Men not integrated in gay community						√					√
Women	√	√		√		√	√	√	√		
Child-bearing women & children breastfeeding	√	√	√						√		
IVDU	√	√	√	√		√	√	√	√	√	√
IVDU and their sexual partners		√									
Recipient of blood/blood products	√	√	√	√			√		√	√	√
Sexual partners of people at risk								√			√
Youth			√	√		√	√	√	√	√	√
Hard-to-Reach/homeless		√					√				
Street youth		√		√		√	√				
Sex trade workers						√	√			√	√
Aboriginal/native peoples		√		√	√	√	√	√			√
Health care workers/workplace	√		√	√		√		√	√		
Prisoners/incarcerated population		√		√		√	√		√	√	√
Culturally diverse population							√		√		
People with disabilities						√					
People who know they are infected with HIV					√	√					
People with STDs						√					

*The risk groups or categories identified in the strategic plans reviewed are not mutually exclusive.

Program Characteristic	WHO	Cdn	AB	BC	SK	ONT	QUE	Nfld	NS	UK	NZ
YEAR OF PLAN	1987	1990	1987	1991	1993	1993	1988	1993	1993	1990	1988
Preventing the Transmission of HIV	√	√	√	√	√	√	√	√	√	√	√
Community-based organizations (CBO's)	√		√	√		√	√	√		√	√
Ethno-cultural organizations	√	√				√					√
Public information and education	√	√	√	√	√	√	√	√	√	√	√
Safer sex and condom promotion in the general public	√	√	√			√		√	√	√	
Safer sex and condom promotion in the workplace	√	√						√	√	√	
Interventions for those at risk of HIV infection	√			√			√				√
Street outreach	√			√		√					
Risk-reduction counselling	√										
Prevention case management	√	√	√						√		
Communications	√	√	√	√	√	√	√	√	√	√	√
Educational campaign	√	√	√	√		√		√		√	√
Television									√	√	√
Newsletters	√									√	√
AIDS hotline	√		√	√					√		
Conferences/seminars	√	√		√							
AIDS clearinghouse/resources	√	√	√							√	
Education	√	√	√	√	√	√	√	√	√	√	√
Professional development for health care workers	√	√	√	√		√	√	√	√	√	√
Education for Caregivers			√	√		√		√			√
School-based programs	√	√	√	√		√	√	√	√	√	√
Work-based programs							√				√
Implementation	√					√		√			√
Test kits	√							√			√
Condoms	√					√		√			

Program Characteristic	WHO	Cdn	AB	BC	SK	ONT	QUE	Nfld	NS	UK	NZ
YEAR OF PLAN	1987	1990	1987	1991	1993	1993	1988	1993	1993	1990	1988
Health care systems											
Testing/Diagnostics	√	√	√	√	√	√		√	√	√	√
Medical assessment available and accessible	√		√	√	√	√	√	√		√	√
Confidentiality and informed consent			√		√	√	√	√	√	√	√
Partner notification						√		√		√	
Evaluation of HIV antibody tests and testing strategies	√		√	√							
Early diagnosis of HIV infection in children	√			√							
Prevention of HIV transmission through blood transfusion	√	√	√					√	√		
Additional blood safety activities in collaboration with the Global Blood Safety Initiative	√			√							
Care and management of people with HIV/AIDS	√	√	√	√	√	√	√	√	√	√	√
Clinical care	√	√	√	√	√	√	√	√	√	√	√
Access to drugs		√		√							
AZT			√	√							
Psychosocial care	√		√			√	√			√	
Counselling	√		√	√		√	√	√	√	√	√
Home and community care	√	√	√	√	√	√		√	√	√	√
Treatment information system		√		√		√	√				
Monitoring care services			√					√		√	√
Monitoring cost of services			√					√		√	√
Financial support/housing	√	√	√	√	√		√	√	√	√	√

Program Characteristic	WHO	Cdn	AB	BC	SK	ONT	QUE	Nfld	NS	UK	NZ
YEAR OF PLAN	1987	1990	1987	1991	1993	1993	1988	1993	1993	1990	1988
Research	√	√	√			√					
Promotion of priority research	√		√								√
Identification of research priorities	√					√			√		√
Promotion of problem-solving research	√					√					
Economic research		√						√			
Legal research		√				√		√			√
Sociological/Behavioral Research			√	√		√			√		√
Epidemiological research, surveillance & forecasting	√	√	√	√		√	√		√	√	√
Epidemiological interactions between HIV, childhood immunizations, tropical disease and other infectious diseases including STDs and tuberculosis	√	√									
Risk factors for HIV transmission in health care settings or at work	√		√						√	√	
Virology						√					
STDs				√		√					
Mother-to-fetus/infant transmission of HIV	√					√					
Drug development	√			√		√					
Collaboration with major research-based pharmaceutical companies developing drugs and vaccines against HIV/AIDS	√					√					
Vaccine development	√			√		√					
Strategy for HIV vaccine development	√										
HIV antigenic variability	√					√					
Identification, assessment and selection of potential field sites for HIV vaccine evaluation	√										
Addressing ethical issues surrounding HIV/AIDS research in human subjects	√										

Appendix C

WHO National Program Objectives and Strategies

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WHO National Program Objectives and Strategies

1. Decentralizing national AIDS program activities to the regional, district and community level.

2. Developing mechanisms to increase the involvement of nongovernmental organizations in program planning and implementation.

3. Costing national AIDS programs and giving a better understanding of extra-program contributions to HIV/AIDS prevention and control.

4. Promoting the integration of national AIDS programs with other components of the health system, particularly programs on maternal and child health/family planning (MCH/FP) and control of sexually transmitted disease.

5. Ensuring technical cooperation in designated areas (health promotion, condom services, epidemiological surveillance, laboratory and blood transmission services, health care and counselling).

6. Strengthening coordination at the national level to ensure that national and international partners work within a useful and mutually acceptable framework.

7. Strengthening the process of national AIDS program monitoring and review, and developing the capability for effectiveness evaluation.

8. Strengthening manpower development programs to support national AIDS programs and related staff.

9. Ensuring sustained and coordinated national and international support for national AIDS programs.

10. Providing and coordinating support for research so as to develop critical knowledge and/or technology to improve HIV/AIDS prevention and control by increasing knowledge about risk behaviours, about risk awareness among risk behaviour groups, about ways of influencing behavioural outcomes, and about individual and community response to HIV/AIDS.

11. Increasing knowledge about the clinical spectrum of HIV in developing countries, including interactions with other infectious agents.

12. Ensuring the conduct of clinical trials of appropriate therapeutic agents in the developing world.

13. Accelerating vaccine development and preparing sites for field (efficacy) studies; developing knowledge about risk factors for HIV transmission.

14. Increasing knowledge about HIV-2 epidemiology.

15. Strengthening research capabilities in accordance with these priorities and national AIDS program needs.

16. Developing and evaluating interventions to improve prevention of sexual transmission (prostitutes/clients, men who have sex with men, youths and adolescents, self-injecting drug users).

17. Strengthening prevention of HIV transmission through blood transfusions and among self-injecting drug users.

18. Assessment of the extent and impact of perinatal transmission.

19. Increasing the production of health promotion material and design of systems.

20. Strengthening health/social service needs assessment and planning.

21. Providing clinical management and support of HIV-infected persons.

22. Evaluating specific interventions and national AIDS programs.